No. 87-1054

IN THE
# Supreme Court of the United States
OCTOBER TERM, 1987

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THE FIRESTONE TIRE & RUBBER CO., *et al.*,
*Petitioners*,
v.
RICHARD BRUCH, *et al.*,
*Respondents*.

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**On Writ of Certiorari to the United States Court of Appeals for the Third Circuit**

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## BRIEF AMICI CURIAE FOR AMERICAN COUNCIL OF LIFE INSURANCE AND HEALTH INSURANCE ASSOCIATION OF AMERICA IN SUPPORT OF PETITIONERS

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## QUESTION PRESENTED

Should courts review *de novo* the claims determinations of an employer acting as fiduciary, administrator and processor of claims for benefits under an unfunded employee benefits plan governed by the Employee Retirement Income Security Act of 1974, or should the determinations of such an employer be reviewed under the arbitrary and capricious standard?

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### INTERESTS OF THE AMICI

The American Council of Life Insurance (the "Council") represents the interests of 650 member companies and is the largest life insurance trade association in the United States. The Health Insurance Association of America ("HIAA") represents 350 member companies and is the largest health insurance trade association in the United States.

Members of the Council and the HIAA play a central role under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA" or the

"Act"). As of 1984, 8% of all employment-related health plans were self-insured. Today, HIAA estimates that commercial health insurance companies alone determine benefits in connection with funded and employer self-insured health programs covering 75.8 million people. Three-quarters of all self-insured plans enlist the aid of an insurance company or other third party to administer claims payment.

The decision of the Third Circuit Court of Appeals at issue in this case directly affects the interests of the Council and the HIAA. *Amici*, without conceding that the Third Circuit's decision applies to their members, are concerned that if the decision were affirmed, it *could* require *de novo* review of every claim for benefits denied under every ERISA plan their members insure or for which they administer claims. Such a result would increase the cost of funding and administering such plans, thereby restricting the availability and scope of welfare benefits members of the Council and the HIAA could provide, even though ERISA was designed by Congress to promote the greater availability of such benefits.[1]

## STATEMENT

Plaintiffs are non-union, salaried employees for Firestone Tire and Rubber Co. ("Firestone"). They brought this action to recover, *inter alia*, termination pay and other benefits allegedly due to them as the result of the sale of their collective bargaining unit to another corporation. Certain individual plaintiffs also claimed damages under section 502(c) of the Act, 29 U.S.C. § 1132(c), for alleged violations of ERISA's disclosure requirements.

[1] *Amici* address in this brief only the first issue (standard of review) presented in the petition for a writ of *certiorari*. The parties have consented to the filing of this brief. Pursuant to Rule 36 of the Rules of this Court, the parties' letters of consent have been filed with the Clerk.



On cross-motions for summary judgment, the District Court ruled in Firestone's favor on all of plaintiffs' then-pending claims. (A73) According to the court, Firestone's determination that plaintiffs were not entitled to reduction-in-force ("RIF") termination pay was neither arbitrary nor capricious. The court noted that nothing in the employee benefit plan or the history of its interpretation indicated that plaintiffs-employees had suffered a RIF. (A53-A54) The court also denied the remainder of plaintiffs' damage claims on other grounds.

A panel of the United States Court of Appeals for the Third Circuit reversed both of these holdings. The court recognized the clear weight of authority supporting the arbitrary and capricious standard of review in civil actions for recovery of ERISA benefits. However, the court held that Firestone's decision on termination pay should be reviewed *de novo*. (A3) In the court's view, Firestone's status as the sole administrator of its unfunded termination-pay plan created a conflict of interest. Because of this presumed conflict, the court varied from the arbitrary and capricious standard. Specifically, the court concluded that it should evaluate Firestone's decision regarding the denial of termination-pay benefits by applying principles of "construction of contracts between parties bargaining at arms' length" after *de novo* review. (A25)

The Court of Appeals also reversed the District Court's decision on other grounds. However, in this brief, *amici* address only the failure of the Third Circuit to apply the arbitrary and capricious standard to Firestone's benefits decision.

## SUMMARY OF ARGUMENT

Although the Third Circuit's decision may be limited to its particular facts, the possibility exists that if it were given a broad reading, millions of claims denied by life and health insurers under ERISA employee benefit

plans could be subject to *de novo* review. *De novo* review would destroy the careful balance between the desire of Congress, on the one hand, to provide prompt claims resolutions under ERISA plans, and on the other, to encourage ERISA plan formation by controlling plan costs —a balance which Congress worked hard to achieve. It would also burden the court with review of claims large and small, in a way Congress never intended.

The balance which Congress sought to achieve can be preserved by requiring that all ERISA claims denials be reviewed by the courts under the arbitrary and capricious standard. That is the standard which all Circuit Courts of Appeals—including, in most instances, the Third Circuit—have applied in reviewing ERISA claims, and it is also the standard applied in reviewing claims arising under the Labor Management Relations Act of 1947 ("LMRA"). This Court has strongly emphasized that actions arising under ERISA were intended by Congress to arise in precisely the same way as actions arising under the LMRA. Requiring *de novo* review of certain ERISA claims while reviewing virtually identical LMRA claims under the arbitrary and capricious standard would impermissibly—and contrary to congressional intent—require such claims to arise differently in federal and state courts.

Finally, the Third Circuit's decision wrongly requires federal *and* state courts to determine, as a preliminary issue, whether an ERISA fiduciary has a conflict of interest in the context of a civil action for recovery of ERISA benefits. Congress expressly reserved to the *federal* courts jurisdiction of fiduciary conflict claims. § 502(e) of the Act, 29 U.S.C. § 1132(e). This Court should not permit an end-run around the jurisdictional barrier erected by Congress by permitting state courts to decide issues of fiduciary conflict under the pretext of evaluating a claim for recovery of ERISA benefits.



## ARGUMENT

**CONGRESS, AFTER THOROUGHLY BALANCING THE NEED FOR PROMPT AND FAIR ERISA CLAIMS REVIEW PROCEDURES AND THE PUBLIC INTEREST IN ENCOURAGING THE FORMATION OF EMPLOYEE BENEFIT PLANS, DEVELOPED A CAREFULLY-CRAFTED CIVIL ENFORCEMENT SCHEME WHICH WOULD BE SUBSTANTIALLY UNDERMINED IF THIS COURT ADOPTED THE *DE NOVO* STANDARD OF REVIEW ADVOCATED BY THE THIRD CIRCUIT IN *BRUCH v. FIRESTONE TIRE AND RUBBER CO.*; THE THIRD CIRCUIT SHOULD THEREFORE BE REVERSED AND THE DECISION OF THE DISTRICT COURT, WHICH APPLIED THE ARBITRARY AND CAPRICIOUS STANDARD IN REVIEWING THE DENIAL OF PLAINTIFFS' CLAIMS, SHOULD BE REINSTATED.**

### A. *De Novo* Review Impermissibly Tampers with ERISA's "Comprehensive" Remedial Scheme by Potentially Allowing Millions of ERISA Plan Participants and Beneficiaries to Challenge Anew Every Denial of Benefits under Employee Benefit Plans.

ERISA's "exclusive," "comprehensive civil enforcement scheme . . . represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, —— U.S. ——, 107 S.Ct. 1549, 1556 (1987).[2] Its

[2] By establishing "minimum standards and safeguards" for privately-funded and -administered ERISA plans, Congress sought to retain "the freedom of decision-making vital to [employee benefit] plans" and to "further[ ] . . . the growth and development" of such plans. 1974 U.S. Code Cong. & Admin. News at 4849-50. Rep. Ullman, one of ERISA's principal architects, emphasized that ERISA had been "carefully designed to provide adequate protection to employees" while simultaneously "provid[ing] a favorable setting for the growth and development" of private benefits plans. 3 Legislative History of the Employee Retirement Income Security Act of

" 'carefully integrated civil enforcement provisions found in § 502(a) [29 U.S.C. § 1132(a)] of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other [ERISA] remedies that it simply forgot to incorporate expressly.' " *Id.* at —, 107 S.Ct. at 1556 (*quoting Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985) (emphasis in original)). Notwithstanding this Court's repeated statements that the civil remedies available under ERISA are "exclusive" and "comprehensive," *Pilot Life, supra*, at ——, 107 S.Ct. at 1549, 1551, 1555, 1556, the Third Circuit, in *Bruch v. Firestone Tire and Rubber Co.*, 828 F.2d 134 (1987), *cert. denied*, —— U.S. ——, 108 S.Ct. 1288 (1988), impermissibly " 'tamper[ed] with an enforcement scheme crafted [by Congress] with . . . evident care.' " *Pilot Life, supra*, at ——, 107 S.Ct. at 1556 (*quoting Russell, supra* at 147). Under the Third Circuit's holding, ERISA plan participants or beneficiaries may raise, in the first instance—before federal *and* state courts—questions concerning an ERISA fiduciary's alleged impartiality in the context of a civil action for recovery of benefits, even though ERISA contains no remedial or jurisdictional provision allowing them to do so.[3] Under the Third Circuit's ruling, if a court found that "no assurance of [a fiduciary's] impartiality" were present, *de novo* review of *every* civil claim for ERISA

1974, at 4673 (1976). He found it "axiomatic" that "plans cannot be expected to develop if costs are made overly burdensome." *Id.* at 4673 (1976). "[T]he entire statute is a finely tuned balance" between protecting benefits for employees" and "limiting the cost to employers." *A-T-O, Inc. v. Pension Benefit Guaranty Corp.*, 634 F.2d 1013, 1021 (6th Cir. 1980).

[3] A civil action to recover ERISA plan benefits may be brought by a plan "participant or beneficiary" § 502(a)(1)(B) of the Act, 29 U.S.C. § 1132(a)(1)(B). Throughout the remainder of this brief, although only the right or capacity of a plan "participant" to bring such an action is discussed, it is understood that a plan "beneficiary" has the same right or capacity.



benefits could be required. *Bruch v. Firestone Tire and Rubber Company, supra*, 828 F.2d at 144.

The Third Circuit's decision, if upheld, could have a devastating effect on ERISA plan formation, extending far beyond the narrow confines of *Bruch*. Group life and health insurers provide insurance and claims services to *millions* of ERISA plan participants, many of whom file dozens of claims for benefits each year. Under the *Bruch* decision, every denial of benefits challenged by each and every one of those millions of participants could *potentially* require federal and state courts to conduct *de novo* review. No such result was ever intended under ERISA. The Third Circuit should therefore be reversed. Moreover, the decision of the District Court below, at 640 F. Supp. 519 (E.D. Pa. 1986)—which applied the arbitrary and capricious standard in reaching its conclusion, thereby precluding *de novo* review—should be reinstated.

The *Bruch* decision *can* be limited to its particular facts. Indeed, the Third Circuit attempted to do so when it defined the "rub" that caused it to conclude *de novo* review was required:

> . . . The "rub" is that the plan administrator is Firestone itself—which is also the sole source of funding for the plan at issue . . . .

*Bruch, supra*, 828 F.2d at 136. The problem comes from the Third Circuit's further explanation of this "rub." According to the Third Circuit, Firestone, as employer, plan fiduciary and administrator, presented "no *assurance* of . . . impartiality" in the processing of claims for benefits. *Id.* at 144 (emphasis added). In its effort to give substance to the alleged appearance of partiality, the Third Circuit observed that "every dollar saved by the administrator on behalf of his employer is a dollar in Firestone's pocket." *Id.* The court reasoned that this lack of "assurance of . . . impartiality" required *de novo* review whenever it was present. *Id.* at 136, 144-45.

Thus, an ERISA plan participant could argue that he is entitled to *de novo* review under the *Bruch* decision if he can show that (1) the party denying his claim had fiduciary status under ERISA, and (2) there was no "assurance" that the fiduciary would be impartial in denying the participant's claim.

The *Bruch* decision, if upheld, *could* therefore affect the entire United States life and health insurance industries. This Court implicitly suggested in *Pilot Life* that insurance companies making claims determinations may be "fiduciaries" within the meaning of ERISA. *Id.* at ——, 107 S.Ct. at 1555-56.[4] Hence, the *potential* for an insurance company to meet the first prong of the *Bruch* test exists. To determine whether an insurance company could also possibly meet the second prong of that

[4] In discussing whether the plaintiff's state-law "bad faith" claim against an insurance company was preempted by ERISA in *Pilot Life*, *supra*, this Court noted, at ——, 107 S.Ct. at 1556, that

> Under the civil enforcement provisions of § 502(a) [29 U.S.C. § 1132(a)], a plan participant or beneficiary may sue to recover benefits due under the plan, to enforce the participant's rights under the plan, or to clarify rights to future benefits. Relief may take the form of . . . an injunction against a plan administrator's improper refusal to pay benefits. A participant or beneficiary may also bring a cause of action for breach of fiduciary duty, and under this cause of action may seek removal of the fiduciary. §§ 502(a)(2), 409 [29 U.S.C. § 1132(a)(2), 1109].

There has, however, been debate among the District Courts concerning the fiduciary status of insurance companies acting as insurers or claims processors for ERISA plans. *Compare Eaton v. D'Amato*, 581 F. Supp. 743, 745 (D.D.C. 1980) (suggesting that claims administrator of ERISA plan could be fiduciary within the meaning of ERISA if administrator had ultimate responsibility for claims determinations) *with Cate v. Blue Cross and Blue Shield*, 434 F. Supp. 1187, 1190 (E.D. Tenn. 1977) (holding that insurance policy was asset of ERISA plan and that insurance company, which merely paid claims with respect to that asset, was *not* fiduciary within meaning of ERISA; only named ERISA fiduciary, who presumably had control of plan assets, was fiduciary).



test—inability to provide "assurance" of impartiality—requires an examination of the services insurers render within the scope of ERISA.

Primarily, insurance companies render two types of services with respect to ERISA plans—they provide coverage under fully-insured plans, such as the plan at issue in *Pilot Life*, and they administer claims payment for employers who maintain self-funded plans, such as the plan at issue in *Light v. Blue Cross and Blue Shield*, 790 F.2d 1247 (5th Cir. 1986).

Under a fully-insured plan an insurer typically assumes a risk for a fee, then pays on that risk from a pool of funds. The greater the amount of money the insurer withdraws from the pool in claims payments, the less the insurer will make in profits on its assumed risk, and vice-versa.[5] Thus, the "rub" allegedly present for employers in *Bruch* may provide a tool to aggressive plaintiffs for use against insurance companies. A plan participant, on the strength of *Bruch*, could attempt to convince a court that "every dollar provided in benefits is a dollar spent by [the insurer]; and every dollar saved [by the insurer] is a dollar in [the insurer's] pocket." *See Bruch*, *supra*, 828 F.2d at 144.

Administrative services contracts do not involve an insurer's funds directly; rather, they involve the employer's funds. However, to the extent that renewal of an administrative services contract is assured by an employer's satisfaction with an insurer's distribution of his funds, the performance of administrative services could be characterized as something more than a disinterested activity. It is therefore possible for plan participants to

[5] Of course, the realities of the marketplace assure that companies that indiscriminately deny claims will fail to satisfy their clients and lose business; companies that pay claims promptly and fairly will satisfy their clients and attract business. The independent status and regulation of insurers by the marketplace substantially differentiates them from employers deciding whether or not to pay benefits under an unfunded plan.

argue that insurance companies—whether providing insurance or administering claims—are unable to provide the "*assurance* of . . . impartiality" necessary to avoid *de novo* review under *Bruch*.[6]

If the *Bruch* decision were given such a broad interpretation, every denial of benefits by an insurer under an ERISA plan—even the denial of a $2.00 claim for drugs which an insurer found to be "medically unnecessary"—could be subject to *de novo* review. And not only in federal courts—in state courts, too.[7] The cost of such review would be an enormous burden to the judicial system, insurers, and employers alike.[8] But in the end, the

[6] However, even assuming *Bruch* were upheld, there are persuasive arguments to support the *non*-applicability of *Bruch* to many claims denials by insurers, one of which has been noted by the Third Circuit in *Shiffler v. Equitable Life Assurance Society*, 838 F.2d 78, 83 (1988) ("[W]e do not understand [the *Bruch*] case necessarily to apply in a situation . . . involving *'personal claims for benefits,' see Struble* [*v. New Jersey Brewery Employees' Welfare Fund*, 732 F.2d 325 (3d Cir. 1984)] at 333 . . ." where no issue of contract inerpretation affecting plan participants as a whole is raised (emphasis added)).

[7] The Third Circuit applies the *Bruch* test in the context of reviewing a claim for recovery of benefits. *Bruch v. Firestone Tire and Rubber Co., supra*, 828 F.2d at 136. Civil actions for recovery of benefits—whether pension benefits or fully-insured or insurer-administered benefits—are brought pursuant to § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B). State courts are provided with concurrent jurisdiction of all (a)(1)(B) claims—and *only* such claims—by § 502(e), 29 U.S.C. § 1132(e).

[8] For one thing, the *Bruch* standard may be incomprehensible, leading to great difficulty in application and requiring substantial litigation to achieve clarification. The Third Circuit itself appears to have questioned its status and intelligibility in *Shiffler v. Equitable Life Assurance Society, supra*, 838 F.2d at 83, n.7 ("We recognize that in *Bruch* the arbitrary and capricious standard was not applied *but we do not understand* that case *necessarily* to apply in a situation such as this involving 'personal claims for benefits,' [citation omitted] even though it could hardly be said that Equitable is disinterested in this matter" (emphasis added)). The Third Circuit has also lamented that the *Bruch* standard is "complex." *Eckersley v. WGAL TV, Inc.*, 831 F.2d 1204, 1208 (1987).



greatest cost would be borne by plan participants—the very parties Congress intended to protect. *De novo* review—with its attendant burdens of additional time and cost for private parties that fund plans—*destroys* the "careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans" that Congress worked so hard to achieve—and in fact, to date, *has* achieved. *See Pilot Life, supra*, at ——, 107 S.Ct. at 1556.[9]

Such a drastic result is not supported by the clear language of ERISA. Employers are permitted to provide ERISA benefits "*through the purchase of insurance* or otherwise . . . ." § 102(1), 29 U.S.C. § 1002(1). Applicable regulations anticipate that an insurer, in providing or processing claims for benefits under an ERISA plan, might be in a position similar to that which the Third Circuit characterized in the *Bruch* decision as giving rise to a potential conflict of interest.[10] While Con-

[9] The Third Circuit off-handedly dealt with the cost issue by acknowledging that "deferring to [an] administrator's decision w[ould] make proceedings faster," but found that "the speed is attained by sacrificing the impartiality of the decisionmaker," resulting in "too great a cost." *Bruch v. Firestone Tire and Rubber Co., supra*, 828 F.2d at 144, n.10. This argument ignores the congressional intent shown by ERISA's careful balancing of competing interests and overlooks the express, detailed statutory safeguards highlighted by this Court in *Pilot Life, supra*, at ——, 107 U.S. at 1555-56, which Congress intended would provide explicit remedies in the event that a decisionmaker's impartiality rose to the level of an actionable breach under ERISA. Furthermore, this Court has recognized the value of alternate review procedures, comparable to those mandated by ERISA. *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 219 (1985) (lawsuits arising under the LMRA cannot be filed until internal collective bargaining procedures have been exhausted so as to "preserve[ ] the central role of arbitration in our 'system of industrial self-government.'" [Citation omitted]).

[10] The regulations, while acknowledging that benefits under an employee benefit plan may be provided or administered by insurance companies, nevertheless permit those companies to process claims

gress gave plan fiduciaries responsibility for implementing ERISA's mandatory internal review procedures, Department of Labor Regulations permit insurance companies to perform those procedures.[11] The procedures are *mandated* by section 503 of the Act, 29 U.S.C. § 1133. The Third Circuit's decision—despite the mandatory nature of ERISA's internal review procedures, which form the cornerstone of ERISA's comprehensive remedial scheme—renders that review meaningless in all cases where *de novo* review is required.[12] If the *Bruch* decision were given its broadest possible reading, the effectiveness of ERISA's mandated claim review procedures—which Congress *did* require— would therefore be greatly diminished, while *de novo* review— which Congress did *not* require— would burgeon, destroying ERISA's delicate balance of congressionally-recognized competing interests while unreasonably and unfairly burdening the courts.

### B. While *De Novo* Review Destroys the Delicate Balance Among Competing Interests Congress Sought to Achieve, Application of the Arbitrary and Capricious Standard of Review to Civil Actions Arising Under ERISA Preserves that Balance.

The Third Circuit determined to require *de novo* review after rejecting application of the arbitrary and capricious standard. The District Court, at 640 F. Supp. 519 (E.D. Pa. 1986), had applied the "arbitrary and capricious" standard in reviewing the *Bruch* plaintiffs' claim. Under the arbitrary and capricious standard, *de novo* review is

for benefits, while imposing an obligation on insurers to provide notice of their claims determinations and a reasonable opportunity for review. 29 C.F.R. § 2560.503-1(c), (g)(2).

[11] *See* brief, n.10, *supra*.

[12] *De novo* review could encourage plan participants to hold back information which might have enabled an internal reviewer—including an insurance company—to favorably assess a participant's claim, in the hope of submitting that information later and obtaining a more sympathetic result from a court.



precluded. *See, e.g., Brandon v. Metropolitan Life Ins. Co.*, 678 F. Supp. 650, 655 (E.D. Mich. 1988) ("*de novo* factual hearing of the claimant's eligibility for benefits" is not permitted under arbitrary and capricious standard). Application of the arbitrary and capricious standard therefore avoids the circumvention of ERISA's carefully-crafted remedial scheme that *de novo* review would encourage. It preserves the delicate balance between competing interests that Congress sought to achieve.[13] Thus, while the Third Circuit's decision to require *de novo* review should be reversed, the decision of the District Court, which applied the arbitrary and capricious standard of review, should be reinstated.

The District Court below, in applying the arbitrary and capricious standard, followed the lead of every other Circuit Court of Appeals to address the appropriate standard of review under ERISA—*see, e.g., Jestings v. New England Telephone & Telegraph Co.*, 757 F.2d 8, 9 (1st Cir. 1985); *Miles v. New York State Teamsters Conference Pension & Retirement Employee Benefit Plan*, 698 F.2d 593, 599 (2d Cir. 1983), *cert. denied*, 464 U.S. 829 (1983); *LeFebre v. Westinghouse Electric Corp.*, 747 F.2d 197, 204 (4th Cir. 1984); *Bayles v. Central States, Southeast & Southwest Areas Pension Fund*, 602 F.2d 97, 99-100 (5th Cir. 1979); *Blakeman v. Mead Containers*, 779 F.2d 1146, 1149-50 (6th Cir. 1985); *Wardle v. Central States, Southeast & Southwest Areas Pension Fund*, 627 F.2d 820, 823-24 (7th Cir. 1980), *cert. denied*, 449 U.S. 1112 (1981); *DeGeare v. Alpha Portland Industries, Inc.*, 837 F.2d 812, 814-15 (8th Cir. 1988); *Elser v. I.A.M. National Pension Fund*, 684 F.2d 648,

[13] It also allows courts to promptly decide cases before them on motion for summary judgment, since additional fact finding is not permitted, thereby affording the prompt claims settlement Congress sought to provide. *See, e.g., Bachelder v. Communications Satellite Corp.*, 837 F.2d 519, 523 (1st Cir. 1988); *Moore v. Reynolds Metals Co. Retirement Program for Salaried Employees*, 740 F.2d 454, 455, 457 (6th Cir. 1984).

654 (9th Cir. 1982), *cert. denied*, 464 U.S. 813 (1983); *Carter v. Central States Southeast & Southwest Areas Pension Fund*, 656 F.2d 575, 576 (10th Cir. 1981); *Griffis v. Delta Family-Care Disability*, 723 F.2d 822, 825 (11th Cir. 1984); *Maggard v. O'Connell*, 671 F.2d 568, 570-71 (D.C. Cir. 1982). It even followed what had been the lead of the Third Circuit—*see Struble v. New Jersey Brewery Employees' Welfare Fund*, 732 F.2d 325, 333 (1984)—and may well have struck closer to the current inclination of the Third Circuit as expressed in *Shiffler v. Equitable Life Assurance Society*, 838 F.2d 78, 83 (1988)—the Circuit's leading post-*Bruch* decision to discuss the applicable standard of review—than did the Third Circuit in *Bruch*.

The District Court properly found, under the arbitrary and capricious standard, that "where the terms of [a] policy are susceptible to more than one *reasonable* interpretation, ERISA mandates that the court not substitute its judgment for that of the [plan] administrator." *Bruch v. Firestone Tire and Rubber Co.*, 640 F. Supp. 519, 524 (E.D. Pa. 1986) (emphasis added). It also noted that "case law support[ed] Firestone's interpretation of the Termination Pay Plan" there at issue, *id.* at 525—the same interpretation which led the Third Circuit to require *de novo* review because, allegedly, Firestone's administrator could not "assure" his impartiality in having reached an identical conclusion.

The District Court framed the arbitrary and capricious standard in a way similar to that of many of the United States Courts of Appeals. While the standard has been described by the Circuits in differing terms, it has perhaps been given its simplest and clearest expression in *Jestings v. New England Telephone & Telegraph Co.*, 757 F.2d 8 (1st Cir. 1985). There, the First Circuit noted that

> "[w]here both the trustees of a pension fund and a rejected applicant offer rational, though conflicting, interpretations of plan provisions, the trustees' interpretation must be allowed to control." *Miles v. New York State Teamsters Conference Pension and Retirement Fund Employee Benefit Plan*, 698 F.2d 593, 601 (2d Cir.), *cert. denied* [464] U.S. [829], 104 S.Ct. 105, 78 L.Ed.2d 108 (1983); *see also Ponce v. Construction Laborers Pension Trust for Southern California*, 628 F.2d [537] at 542 [(9th Cir. 1980)] ("It is for the trustees, not judges, to choose between various reasonable alternatives."); *cf. Palino v. Casey*, 664 F.2d 854, 858 (1st Cir. 1981) ("In judging the actions taken by trustees in the course of managing an employment benefit plan, our inquiry is limited to determining whether the actions were arbitrary and capricious in light of the trustees' responsibility to all potential beneficiaries."); *Rueda v. Seafarers International Union of North America*, 576 F.2d 939, 942 (1st Cir. 1978) ("Unless the trustees interpretation of the plan is arbitrary and capricious, or without rational basis, it may not be disregarded").



*Jestings v. New England Telephone & Telegraph Co.*, *supra*, 757 F.2d at 9 (*quoting Govoni v. Bricklayers, Masons and Plasterers International Union, Local No. 5 Pension Fund*, 732 F.2d 250, 252 (1st Cir. 1984)). Under this phrasing of the standard, as in the decision of the District Court below, rationality is the key. Despite this, the Third Circuit erroneously characterized the standard as "outcome determinative." *Bruch v. Firestone Tire and Rubber Co.*, *supra*, 828 F.2d at 147. It is not. A plaintiff may recover benefits under the arbitrary and capricious standard by showing that any particular denial of benefits lacked a rational basis. *Jestings v. New England Telephone & Telegraph Co.*, *supra*, 747 F.2d at 9. The *Bruch* plaintiffs simply failed to do so.

In rejecting application of the arbitrary and capricious standard despite the weight of judicial precedent in its favor, the Third Circuit acknowledged, as it should have, that the standard has been applied in the context of reviewing ERISA claims denials because it is used in re-

## II. THE COURT OF APPEALS' BROAD CONSTRUCTION OF THE TERM "PARTICIPANT" HAS NO BASIS IN THE STATUTE.

The court of appeals held that a plan administrator is required under ERISA to provide information to former employees, even if they are not eligible and have no reasonable expectation of becoming eligible for plan benefits. The court reached this result by interpreting the statutory definition of "participant" as including persons "who claim to be but in fact are not" entitled to a benefit under an ERISA-regulated plan. Pet. App. A42. This interpretation is without support in the statute.

ERISA defines "participant" as:

> any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from any employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1002(7).

"The term participant is of considerable importance within ERISA's statutory scheme because numerous rights under that scheme are limited to those who are included within that term." *Saladino* v. *I.L.G.W.U. National Retirement Fund*, 754 F.2d 473, 476 (2d Cir. 1985). A participant must be sent certain plan documents at specified times and intervals (29 U.S.C. § 1024(b)(l)); may examine plan documents at any time at specified locations (*id.* § 1024(b)(2)); must be sent financial information on an annual basis (*id.*



§ 1024(b)(3)); must be sent copies of plan documents on request (*id.* § 1024(b)(4)); and must be sent information as to his accrued and nonforfeitable benefits on request once a year (*id.* § 1025(a)). In addition, a participant may institute a civil action to enforce his rights under ERISA (*id.* § 1132(a)); and may be entitled to attorneys' fees (*id.* § 1132(g)).

This case involves Section 502(c) of ERISA, 29 U.S.C. § 1132(c), which provides that a participant may recover penalties from a plan administrator for failure to respond in timely fashion to the participant's request for information. Section 502(c) states in pertinent part:

> Any administrator who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant . . . by mailing the material requested . . . within 30 days after such request may in the court's discretion be personally liable to such participant . . . in the amount of up to $100 a day from the date of such failure or refusal. . . .

In the district court, respondents sought damages under Section 502(c), alleging that the plan administrator failed to respond properly to their requests for information. The district court held that, because respondents were not entitled to benefits under any of Firestone's plans, they were not "participants" and thus could not assert a right to receive information concerning those plans. Pet. App. A69-A72.

In reversing the district court, the court of appeals read the language "any . . . former employee who . . . *may*

*become eligible* to receive a benefit," in the statutory definition of "participant," 29 U.S.C. § 1002(7) (emphasis added), as equivalent to "*someone who claims to be*" eligible to receive a benefit (Pet. App. A41 (court's emphasis)).

Congress could not possibly have intended this result. The words "may become eligible," in their ordinary, natural sense, refer to someone who, based on present circumstances and activities, has the opportunity to gain eligibility. In the practical application of employee benefit plans, this means someone who would be expected to attain eligibility by virtue of the passage of time, assuming that the underlying circumstances remain unchanged. This would include all present employees and those former employees who have worked for the minimum period specified in the plan but have not attained the necessary age to receive benefits. *See Nugent* v. *Jesuit High School of New Orleans*, 625 F.2d 1285, 1287 (5th Cir. 1980). A former employee who has no right under a particular plan to attain eligibility in the future simply does not fit within the definition of "participant," because he is not "eligible" for benefits nor is he in a position in which he "may become eligible" for benefits.

Furthermore, Congress could not have meant to require an employer to continue to send information, on a continuing basis, to all former employees, and to respond to specific requests for individualized information from former employees where those former employees have not stated a colorable claim for benefits. Yet that is the result of the court of appeals' broad reading of "participant" as including an individual "even if he is no longer an employee and is not entitled to any benefits other than those he has already received." Pet. App. A3.



As the Second Circuit has concluded, any interpretation of "participant" that would broadly include an amorphous group consisting of all former employees who merely "claim" entitlement to benefits cannot be reconciled with the statutory scheme:

> The mandatory requirement that plans send certain documents at specified intervals and annual financial information to participants strongly suggests that this group must be easily identifiable and one with a substantial interest in the matters conveyed. . . . Similarly, the provision that the plans inform participants who so request of their accrued and nonforfeitable benefits implies that the persons entitled to such disclosure have a demonstrable claim. We believe, therefore, that Congress intended the term participant to limit the various reporting and disclosure obligations imposed on plans to identifiable persons with a substantial interest in the matters conveyed and not to burden plans with the cost of reporting and disclosing to an amorphous, undefined group of individuals who lack any such interest. Any other reading of the statute would reduce the amounts available to actual beneficiaries of plans for no statutory purpose.

*Saladino* v. *I.L.G.W.U. National Retirement Fund*, 754 F.2d at 476.

In enacting ERISA, Congress recognized the voluntary nature of private benefit plans, and therefore sought to minimize the financial burdens to be placed on the system by the additional statutory requirements. *See, e.g.* H.R. Rep. No. 93-533, 93d Cong., 1st Sess. 1 (1973); 120 Cong. Rec. 4295 (1974) (remarks of Rep. Ullman). The decision below,